

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-002127

438

STATE FILE NUMBER

AMENDED

Registration District No. 149
FILED FEB 13 1962

Primary Registration District No. 1-002 Registrar's No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY JACKSON	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY	a. STATE CALIFORNIA COUNTY RIVERSIDE	c. CITY OR TOWN PALM SPRINGS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RESEARCH HOSPITAL		d. STREET ADDRESS 36-903 PALM VIEW RD.	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HAROLD L WIEDER		4. DATE OF DEATH Month Day Year JANUARY 23 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/31/93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VICE-PRESIDENT		10b. KIND OF BUSINESS OR INDUSTRY UNIVERSAL UNDERWRITERS	
13a. FATHER'S NAME CHARLES WIEDER		13b. MOTHER'S MAIDEN NAME LaGRANGE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT Address 4901 W. 81 ST. ST. JOE B. ELLIOTT PRAIRIE VILLAGE, KAN.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contusion & hemorrhage brain with hemiplegia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Affected at Research Hosp		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) Two Car Collision	
20c. TIME OF INJURY Hour Month, Day, Year 1-11-62	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	20f. CITY, TOWN, OR LOCATION COUNTY STATE Prairie Village Johnson Kansas
21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at 10:15 A. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Hugh H. Owens Esq.		22b. ADDRESS 152 Union Station	22c. DATE SIGNED 1-24-62
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/25/1962	23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY
24. FUNERAL DIRECTOR ADDRESS D.W. NEWCOMER'S SONS, KANSAS CITY, MO. 1331 BRUSH CREEK BLVD.		25. DATE RECD. BY LOCAL REG. 1-24-62	26. REGISTRAR'S SIGNATURE Ruth Long

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Norman W. Larson

Licensed Embalmer No. 4889

P. O. Address Lathrop, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.